Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 York & Scarborough Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Mark ARMITAGE, Assistant Coroner for the coroner area of North Yorkshire and York
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 03 March 2025 I commenced an investigation into the death of Malcolm WELCH aged 88. The investigation concluded at the end of the inquest on 10 March 2026. The conclusion of the inquest was that: The deceased had a medical history of prostate cancer, pulmonary fibrosis and spinal stenosis. He also had a history of falls. On the 19th of January 2025 the deceased presented at the York Hospital Emergency Department with a history of constipation which had lasted for several days. A falls risk assessment was undertaken on admission to the Emergency Department at hospital and again on admission to the Frailty Assessment Unit and precautions were in place to reduce the risk of him falling, such as the use of a call bell and instructions on its use. On the 22nd of January 2025 the deceased was transferred to Ward 35; he was alert and orientated and had capacity. At 9pm on the 22nd of January 2025 he suffered an unwitnessed fall, having mobilised independently to the toilet. This fall caused fractures to the 5th to 8th ribs on the right side. Radiology did not demonstrate any intracranial pathology or fractures to the spine following this fall. The deceased was diagnosed with COVID-19 on the 30th of January 2025 and was thereafter found to have also developed pneumonia. Antibiotics were commenced on 30th January 2025 and administered until 5th February 2025. The deceased appeared to be recovering from the infection but his condition deteriorated whilst in hospital and he was discharged home on 19th February 2025, with his family undertaking to care for him before a formal package of care was put in place. His condition continued to deteriorate and died at home on 22nd February 2025.
4	**CIRCUMSTANCES OF THE DEATH** The deceased had a medical history of prostate cancer, pulmonary fibrosis and spinal stenosis. He also had a history of falls. On the 19th of January 2025 he presented at the York Hospital Emergency Department with a history of constipation which had lasted for several days. A falls risk assessment was undertaken on admission to the Emergency Department and again on admission to the Frailty Assessment Unit. He was assessed as being able to mobilise with a walking frame and the assistance of one member of staff. On the 22ndof January 2025 he was transferred to Ward 35. He was alert and orientated and had capacity. At 9pm on the 22nd of January 2025 he suffered an unwitnessed fall, having mobilised independently to the toilet. At the time of that fall, it is unlikely that he had the use of the walking frame that he had been assessed as needing and which had been allocated to him whilst in hospital, although it is likely that he had in fact used a walking

	frame that belonged to another patient. This fall caused fractures to the 5th to 8th ribs on the right side. He subsequently developed pneumonia whilst still in hospital and which was the direct cause of his death. The fractures to the ribs constituted a significant contributory cause of the death, alongside prostate cancer and pulmonary fibrosis. He was discharged home on the 19th of February 2025 with his family undertaking to care for him before a formal package of care was put in place. He continued to deteriorate and died at home on the 22nd of February 2025.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) During the course of the inquest, evidence was heard from Ward Manager [redacted] the Ward Manager from Ward 35. She confirmed that it was unlikely that the deceased had been provided with his allocated walking frame on admission to Ward 35; the clinical notes did not refer to him having been provided with that mobility aid. The evidence of [redacted] was that even if a walking frame had been allocated to a patient at an earlier stage in the hospital admission process, that walking frame would not automatically follow the patient on their onward journey onto other wards or other areas of the hospital. The evidence was that a reassessment would be undertaken on admission to a new ward and a decision would then be taken in relation to the provision of such mobility aids. In this case, it is likely that the deceased had been on Ward 35 for around 2 hours and 40 minutes and he still had not been provided with an allocated walking frame for his own use. Whilst it cannot be said that this lack of a walking frame contributed to the deceased's fall, given that he likely used a frame belonging to someone else, it is a matter of concern that a patient could be admitted onto a ward without being provided with the mobility aids that they had been previously assessed by the hospital as requiring and which had already been allocated to that patient at an earlier stage in the hospital admission process. I am therefore concerned about the consistency of the provision of such mobility aids during the course of a patient's admission. I am concerned that this creates a risk of future deaths to other patients in circumstances where they are transferred onto wards without them having the mobility aids which they have been assessed as requiring, and with which they have already been provided at an earlier stage whilst in hospital.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by May 06, 2026. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted]

	I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.
9	**Dated: 11/03/2026** [redacted] **Mark ARMITAGE** **Assistant Coroner for** **North Yorkshire and York**